Medi-Cal Provider Number Verification Form

Address to send requested information:

_____
Name

_____
Address

_____
City, State Zip

I. Rendering Provider Information

I _____declare that I am a current Medi-Cal rendering provider with:

_____ _____
(Name of Provider Group) Provider Group Medi-Cal Number

_____
(Address)

and I am requesting a verification of my Medi-Cal provider number.

Signed this _____day of _____, _____
(Day of Month) (Month) (Year)

in _____, State.
(Name of City where signed)

_____ _____
(Signature of Rendering Provider) (Date)

_____ _____
(Medical License Number) (Telephone #)

*A copy of a current Driver's License and/or State Issued Identification Card as well as a current copy of the provider's license to practice medicine must accompany this request in order for it to be processed.

For California Department of Health Services Use Only:	
Verified Provider Number:	Date:

Send completed form and attachments to:

Department of Health Services
Provider Enrollment Branch
Payment Systems Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413